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Article

Clinical Observations for Practitioners

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Abstract

The purpose of this clinical observation is to increase student exposure to real patient cases that explore the challenges, practice behaviors and team-based solutions that improve the quality and safety of patient-centered care. Participants will receive a brief history of the present illness (HPI) to familiarize them with the patient prior to the activity. They will then have the opportunity to observe an interprofessional unfolding case study, witnessing and evaluating firsthand the potential dilemmas and solutions related to the case under the direction of the appropriate practitioners.

Keywords: clinica, observation, practics, sensibility

Introduction

The purpose of this Learning Activity is for students to observe a real-time inpatient team conference in an acute rehabilitation setting. After a brief introduction to the conference by the program manager, students will witness an interprofessional team draw on the expertise of representatives from medicine, nursing, occupational and physical therapy, pharmacy, psychiatry and social work. The team will discuss each patient's treatment plan, short- and long-term goals, current status and plan for discharge. Participants will observe both discussions about new admissions as well as progress reports for patients who have been admitted for longer periods of time. Students will also gain a sense of the role of insurance coverage for patients in this clinical rehab setting. A debriefing following the conference will give students the opportunity to ask questions of and clarify any points of confusion with the program manager.Collaborative Practice Initiatives

Clinical Rounding – The purpose of this IPE activity is to provide a "real-time," collaborative practice learning experience for health professions students. Medical and nursing students meet in person prior

to rounds to review patients' current plans of care, study results, anticipated discharge dates, and interprofessional plans for discharge. Pharmacy and PT students will have an opportunity to participate remotely using a Google Doc. The team will then round both live and remotely using Google Home, collaborating on their patient presentations and coming to understand how individual plans of care are impacted by collaborative practice.

Nursing/Pharmacy Teach Back – The purpose of this learning activity is for nursing and pharmacy students to collaborate together on patient education using the Teach Back method. After reviewing the assessment data in a virtual team huddle via Google Docs, nursing participants will conduct an oral health history with the selected patient, assessing the patient's health history, health literacy and learning needs. They will then relay all findings to the pharmacy participants via Google Docs and the pharmacy students will identify the medication(s) for the subsequent education session. The student team will then have an opportunity to debrief the morning's findings in person with their clinical instructor and preceptor before gathering the appropriate teaching materials and again meeting with the patient. In this final meeting, participants apply the Teach Back method, working to employ appropriate strategies for effective patient-caregiver communication and education while administering patient-centered care.Yet, as this essay will argue, such a clear distinction between bodily and mental suffering cannot be made for all historical periods. The study of self-mutilation in later nineteenth-century psychiatry provides a fitting focus for examining the complexity of notions of body and mind in relation to ideas of pain. In Broome, Swain and Pigram are not alone in the cultural work of 'memory of tradition' of Australia's other cultural histories and alternative ways of being in the world. Indigenous cultural production as the continuation of Indigenous culture and as a living and continuously adapting culture is flourishing, from Wawili Pitjas' Jandamara (with ABC TV) and the popular culturally-based TV cooking show Kriol Kitchen to the beautiful songline animation In Pigram's words of warning. We need to be celebrating these [old] people and their knowledge, and learn from it … If we don't look to our first peoples and their understanding of tree, of land, of natural systems and the way things work, it's all going to disappear very quickly. And I have a feeling we're going to really need that knowledge soon. (cited in Brunes). In her influential text, The Body in Pain, Elaine Scarry made a stark division between physical and psychological pain, suggesting that while the latter has permeated almost every form of literature, the former receives little attention.I Lurujarri Dreaming (Bernadette Trench-Thiedeman with Goolarabooloo community 2012), Goolarri Media's video-training workshops, Magabala Books' publication of works by more than 100 authors, the unique kriol sounds of the Pigram Brothers musical performance, and so on. In the western world the arts are often regarded as different to and separate from the world of politics. In Broome I was reminded that in Indigenous communities, cultural production is considered heavy-lifting and the means of ensuring trans-generational transfer of an Indigenous worldview, which, if we took the time to listen, is precisely what all the reports into Indigenous suicide prevention in Australia say must occur if we are commit-

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ted to stopping this social emergency (Georgatos). As Marrugeku suggest through their work, such knowledge is crucial to an Indigenous understanding of culture and tradition. In this essay, I have tried to suggest that it is also a powerful critique of the discourse of progress and something we all need to learn if we hope to continue to live in this country, indeed if our fragile planet is to continue to sustain life and the different worlds we make for ourselves and our children.

Today, it is widely accepted that self-inflicted injuries hold psychological or emotional meaning, attached to the pain or ritual of inflicting a wound and the physical injury itself.2 Such has not always been the case. Indeed, for much of the nineteenth century discussion of self-mutilation tended to focus on the physical nature of wounds, rather than on the process of inflicting them, which, it was at first assumed, occurred simply from the inability of the individual to feel physical pain. In the later nineteenth century, however, some alienists (asylum psychiatrists) began to show an interest in examining the 'motives' behind self-inflicted injury and published increasingly on the topic. The reasons recorded certainly included the idea that self-mutilation might *relieve* rather than inflict pain, as Scarry suggests; nonetheless, the somatic language often employed in nineteenth-century descriptions of mental illness tended to mean this relief was expressed in physical rather than psychological terms.3

This essay provides an analysis of the overlapping ways in which self-inflicted injury was understood in relation to pain (or, more often, its absence) during the second half of the nineteenth century. Today, it is often assumed that self-mutilation in past centuries was closely associated with suicide: thus, I begin by exploring the complex way in which the topic of self-mutilation was associated with — and, more importantly, differentiated from — medical, legal, and cultural understandings of suicide. However, I will argue that it is a mistake to read late nineteenth-century British texts solely from this preserve. Physiological and psychological meaning is often hard to untangle in the published texts of asylum psychiatrists, and still more so in asylum records. Their interest in motive cannot thus be regarded as either a simple forerunner of psychological approaches to mind *or* a purely somatic understanding of brain mechanism. Rather, as I show in a comparison of British psychiatric approaches, asylum physicians preferred a socio-environmental approach to the symptoms of mental illness. Finally, I look at two seemingly psychological approaches to self-mutilation — those of Richard von Krafft-Ebing and William James — both referenced by British physicians writing on the topic. Despite the alleged psychological context, ideas of sensation continued to permeate such research at the turn of the twentieth century. I conclude that a study of self-mutilation — a topic associated in various ways with pain and suffering — indicates that we cannot view later nineteenth-century psychiatric ideas in terms of the modern separation between physical and psychological pain.

My research focuses on the published texts of British alienists (and European and American texts cited by them), within the period 1860 to 1900, when the bulk of

writing on self-mutilation outside a military context appeared. In addition, I explore the asylum practices of those writing on the topic, including George Savage, Theo Hyslop, and Daniel Hack Tuke (all variously associated with the Bethlem Royal Hospital), and James Adam (superintendent of the Crichton Royal Institution in Dumfries and, later, West Malling Place Asylum). The views of these elite practitioners should not be taken as reflecting the opinions of all alienists of this period. Their involvement in teaching and research (in most instances) may have contributed to their interest in a field of investigation that was not necessarily the focus of all — or even many — of their contemporaries, while their experiences with wealthy or educated patients may also have shaped the field of discussion.4 Nonetheless, their ideas certainly emerged from their asylum practice, and many of these alienists were also highly regarded spokesmen for the asylum system. Their efforts to define and explain the topic of 'self-mutilation' can, therefore, shed much light on general asylum approaches of the period. These, I will argue, were not solely based around concerns with heredity and a tendency to view mental disorder in somatic terms, but also incorporated social and even psychological influences.

Throughout the essay, I will use the terms 'self-injury' and 'self-mutilation' interchangeably to refer to all types of self-inflicted injury — including, but not limited to, amputation, enucleation (plucking out the eye), castration, hair-plucking, and the creation of cuts, bruises, and other skin lesions. Such reflects the nineteenth-century usage of both terms, which were very broadly defined by alienists and those around them.5

Self-Mutilation and Suicide

More recent texts within psychology, psychiatry, and, at times, the history of medicine, tend to assume a close relationship between self-inflicted injury and suicide. This might reflect the emphasis placed by contemporary clinicians on Karl Menninger's landmark study, *Man Against Himself* (1938). The psychoanalytically oriented Menninger regarded self-mutilation as an unconscious mechanism for *avoiding* suicide in the individual, by the concentration of a 'suicidal impulse' on one part of the body as a substitute for the whole. Self-inflicted injuries — including 'self-mutilation, malingering, compulsive polysurgery', and 'certain unconsciously purposive accidents' — were thus incorporated by Menninger under the banner of 'focal suicide'.6 Modern texts (including the only book-length work on self-mutilation, psychiatrist Armando Favazza's *Bodies Under Siege*) often cite Menninger as the first doctor to regard self-mutilation as a topic worthy of discussion, assuming that earlier physicians made no distinction between self-mutilation and suicidal acts.7 Thus, while suicide has received much attention in medical history, other forms of self-inflicted injury have not. For some, self-mutilation appears to be

a clear-cut category, an attitude that has also prevailed in discussion of attempted suicide.8 Similarly, histories of suicide either bypass self-mutilation altogether or fail to acknowledge any distinction — lay or medical — between suicide and other forms of self-inflicted injury prior to the twentieth century, conveying the erroneous impression that none was made. For example, while claiming to discuss the 'History of Suicide and Self Harm', a chapter of German Berrios's work on mental symptoms focuses solely on published literature on suicide.9 The few critical histories of self-mutilation — investigating the way in which ideas of self-harm have been formulated — focus on twentieth-century ideas.10

Yet late nineteenth-century alienists certainly *did* draw a distinction between self-mutilation and suicidal acts. Indeed, as early as 1844, standardized admission papers to the Bethlem Royal Hospital enquired whether a patient was 'disposed to suicide, or otherwise to self-injury', suggesting separate, albeit related, symptoms of mental disorder.11 From the late 1860s, the term 'self-mutilation' increasingly began to appear in published psychiatric papers and asylum case-books, as well as in newspaper articles declaring certain acts to be 'self-mutilation from insanity'.12 Alienists in the later nineteenth century frequently referred to the importance of distinguishing self-mutilation from suicide, although they rarely cited the reason for such distinctions.13 Sometimes, this emphasis may have been to protect the reputation of the asylum, for the public and Lunacy Commissioners alike regarded suicides in asylums as tantamount to neglect (Shepherd and Wright, pp. 175–96). In the Ipswich Asylum Annual Report for 1871, for example, the medical superintendent discussed a case in which a patient died several weeks after having torn out his eye, stating that 'the only remark I should wish to make upon this case is that I never considered it one of suicide, but simply one of self-mutilation'.14 Self-mutilation, although essentially related to suicide, might be presented quite differently: more akin to accidental injury than intentional act. Thus, in the same report from Ipswich, a list of 'accidents' included 'one patient [who] bit off the first joint of her little finger whilst in a state of epileptic delirium' (p. 274). Self-mutilation, like the term 'self-homicide', did not necessarily imply intent.15 Such a distinction between self-mutilation and suicide also served to protect the patient (and his or her family) from the legal and religious consequences of suicide and, indeed, attempted suicide, which had been newly criminalized mid-century (Anderson, p. 263).

Physiology and the Somatic Model of Self-Mutilation

However, for some commentators suicide was depicted as *less* unpleasant and more likely to be rational than self-mutilation. Although suicide went against the supposed 'natural instinct' of self-preservation, it had long been philosophically linked with rational behaviour, a connection which was increasingly emphasized with the revival of Stoicism in the later nineteenth century.16 But where did self-

mutilation fit in relation to 'natural' processes, and what did its occurrence mean? In the 1930s, Menninger warned that his chapter on self-mutilation 'is not very pleasant subject matter. Our experience with pain makes the thought of self-mutilation even more repugnant than the thought of suicide' (Menninger, p. 203). Similarly, discussion of self-mutilation in the previous century was closely connected to philosophies of pain, in particular, the influence of Jeremy Bentham's pleasure/pain model of motivation in mankind (1789), promoted in mid-nineteenth-century psychology by the work of Alexander Bain (despite rejecting other tenets of Utilitarianism, including the 'greatest happiness principle').17 Bain's emphasis on pain and pleasure as the 'two great primary manifestations of our nature' included allusions to physical experience and mental function, using the terms to apply also to misery and happiness (Bain, pp. 31–32). He has thus been well-recognized as playing an important part in the proliferation of parallels between physiological and psychological models of mental action.18 This philosophical approach to pain, in which 'a pain that did not prompt some alleviating action would be no pain', encouraged psychiatrists to emphasize the role of the absence of pain in the self-infliction of injury (Bain, p. 346). In 1875, for example, forensic psychiatrist Richard von Krafft-Ebing claimed that the 'loss of the pain-sense is of great significance in insanity', for it 'may lead to intentional self-injury, brutality in the manner of carrying out suicide [...] [or] accidents'.19 Since a brutal suicide would presumably have the same result (physically, legally, and spiritually) as any more peaceful method, one might wonder why Krafft-Ebing should stress this as a particular concern. Moreover, how could absence of pain be regarded as a motivating factor in self-inflicted injury which did not have a suicidal purpose?

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The construction of a model of self-mutilation based on the supposed perversion of 'natural' instincts towards pain was promulgated by Wilhelm Griesinger (1817–1868). A German neurologist and psychiatrist, Griesinger explicitly rejected traditional psychological and metaphysical classifications of mental disorder. These took into account the manner in which an insane person's speech, demeanour, or actions differed from those in normal life. Instead, Griesinger preferred a division into psychical depression, exaltation, and debility.20 This means of classification, he hoped, would assist in uncovering associated lesions in the brain and nervous system, thus furthering the medico-scientific side of psychology, rooting diagnoses in neurological research into impulse and inhibition.21 Although most psychiatrists, in Britain and Continental Europe, agreed that much investigation was needed before the biological nature of insanity could be firmly established, Griesinger further suggested that, in the absence of hard evidence of pathological change, diagnoses must be

made along the 'entire collection of nervous symptoms', including anomalies of sensation and motion. He divided such irregularities into 'anomalies of sensibility' and 'disorder of the motor power', indicating a number of subcategories in each group. Rather than being a psychical symptom, Griesinger associated self-mutilation with those insanities marked by 'decreased sensibility, by anaesthesia or analgesia'. He cited the example of a patient who 'in part from wantonness, and in part to compel the attendant to send for the physician, had deliberately smashed the first phalanx of his thumb with a brick. This man told me he had not suffered the least pain' (Griesinger, p. 539). Thus, for Griesinger, elevating the status of the physiological symptom meant that the direct motive for self-mutilation could be discarded: the lack of pain was the causatory factor, not the patient's desired result.

While Griesinger's physiological aetiology of insanity was not adopted outright within British psychiatry, the view that self-inflicted injury was based on a combination of the absence of sensation and the influence of an 'insane impulse' often appeared in texts published in the second half of the century. When zoologist William Carmichael McIntosh discussed the topic in a paper 'On Some of the Varieties of Morbid Impulse and Perverted Instinct' two years later, he typified the British approach, connecting a somatic neurological basis with the environmental and hereditary factors thought to influence moral and emotional insanity:

It is found that persons will occasionally castrate themselves, amputate their arms and legs by means of a passing railway train, cut, tear, and burn their bodies, and perform other impulsive acts of torture. Amongst the insane many marked cases are observed.22

If 'many' (rather than all) such acts were symptoms of insanity, this could suggest that some might not be. This issue increasingly became a topic of discussion in the last decades of the century as self-inflicted injury became commonly associated with so-called 'nervous disorders', in particular the 'cutaneous anaesthesia' commonly regarded as a major symptom of hysteria. Nonetheless, in case-studies of self-mutilation published in the Journal of Mental Science from the 1870s, the topic of sensation (and its absence) was often a major focus, used to emphasize the manner in which self-mutilation contravened natural laws.23

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Despite the claimed objectivity of such an approach to self-inflicted injury, classification relied on doctors' reports that patients themselves confirmed that they had, indeed, felt no pain. Griesinger's example is complicated by his inclusion of the other motives cited by his patient, despite having claimed such concerns to be irrelevant within his scheme. As Michael J. Clark has since recognized, new physiological approaches to mental disorder in this period frequently remained complicated by metaphysical or psychological concerns.24When looking at nineteenth-century depictions of self-mutilation, therefore, we cannot attempt to

make any clear divide between physiological and psychological interpretations of behaviour. Indeed, in Britain at least, the majority of those alienists who discussed self-mutilation in the later nineteenth century rejected rigidly somatic interpretations of illness. Savage, for example, was an outspoken critic of Henry Maudsley's 'tyranny of organization': the claim that mental illness was biologically inherited, and thus the inevitable fate of those born of 'nervous' stock.25 Theo Hyslop, meanwhile, emphatically rejected so-called 'medical materialism': the assumption that mental illness could be explained and understood through brain biology alone.26 The difficulties in making distinctions between the mental and physical are brought into clear relief by a closer examination of the case-books kept by these practitioners, which also indicate the complex way in which the interpretation of self-mutilation relied on interaction between doctors and patients. The examination of asylum practice alongside published texts can thus offer us greater insight into psychiatric ideas of the period: theory and practice were not necessarily one and the same.

James Adam, for example, who wrote the five-page definition of 'self-mutilation' for Daniel Hack Tuke's Dictionary of Psychological Medicine (1892), made explicit reference to examples of what he termed 'sexual self-mutilation' in his published definition (p. 1150). This category drew heavily on one particular case he had encountered at West Malling Place. On examining the case records, however, it becomes evident that this was the onlycase of self-mutilation recorded during Adam's ownership of the institution: the relatively rare occurrence of such acts as reported within asylums indicates that we cannot see classifications as simple descriptions of the occurrences of asylum life.27 Instead, definitions were created by bringing together unrelated instances reported by a variety of practitioners. Adam's patient, Captain Henry Puge Halhed, had been admitted to West Malling Place in April 1871, aged 65, over a decade before Adam purchased the institution. Halhed had previously been a Captain in the Bengal Army and, about five years before his admission to West Malling Place, had 'removed the testes & part of the scrotum [...] having the impression he must become a Eunuch to preach to a tribe in the North of India'.28Halhed's ideas were interpreted as religious and sexual delusions by both Adam and his predecessor, Thomas Lowry, although little reference was made in case-books to the somatic context referred to in published works, beyond vague allusions to 'impulse' (a term that could be interpreted both neurologically and psychologically). Indeed, the main focus lay in locating Halhed's self-mutilation within his prior experiences: anxiety over his sexual role, 'religious enthusiasm and excitement', and, in the Dictionary, the acquisition of 'Eastern languages and ways' (Adam, p. 1150). Such an explanation offered a socio-environmental account of self-inflicted in-

jury (in addition to the influence of inherited physical traits located within the individual). Indeed, in his published definition, Adam declared that the only way to understand self-mutilation was by 'an endeavour to trace some of the motives which have prompted to the commission of the acts' (p. 1147): an idea that certainly did not fit within the physiological model proposed by Griesinger, but shows closer links to Bain's associationist psychology.

Like Adam, late nineteenth-century Bethlem physicians George Savage and Theo Hyslop set much store in uncovering the 'motive power' of insane patients.29 Indeed, the socio-environmental model of madness that these physicians shared seems to have encouraged their interest in self-inflicted injury. But what 'motives' did these psychiatrists 'discover' in their patients? Sometimes, these did indeed fit the somatic model of self-injury offered by Griesinger. In 1889, for example, when Isabella Morant was admitted to Bethlem after attempting to cut off her hand with a carving knife (after which it had been amputated), her husband reported that she 'said she had no pain'. While in hospital, Isabella further managed to tear out one eye — something she had long threatened — and the medical officers again reported that 'there has been little or no pain', while the patient 'says she is very happy now & does not intend to do any further injury'.30 However, plenty of other patients did not fit this neat model based around sensation. In the Bethlem Hospital case notes, two other explanations put forward frequently by patients also focused on pain in very different ways: by interpreting self-injury as punishment, or as a form of treatment for pain they were currently experiencing.

While Isabella Morant indicated that her actions (both amputation and enucleation) had been required by a higher power, other patients suggested their injuries were atonement for crimes. Such concepts of punishment often did assume that injuries were painful: for example, although Frederick Humphreys's efforts to burn his arms were interpreted as punishment, the patient apparently claimed that he had trained himself to bear the pain.31This notion of self-mutilation as a form of 'endurance' was sometimes suggested to be a motive behind self-inflicted injuries in sanity as well. Other patients claimed that their injuries, while not painful in themselves, provided 'relief' from other pains they had to bear: such suggestions were almost always couched in physical, rather than mental, terms. An interesting example is self-cutting, which, unlike today, was rarely specified as a distinct form of self-mutilation, possibly due to an alternative framework of interpretation located within medical treatment: phlebotomy, or bloodletting. In 1860, Elizabeth Taylor was reported as having shown

> latterly some indications of a wish to injure herself, [...] to draw blood which she fancies would relieve her [On one occasion] [...] without any obvious cause or previously speaking of it, she rushed into a chemist's shop & asked to be cupped immediately, as the only means to relieve the distress of her head.32

The complicated dialogue here between self-injury and self-treatment is apparent. Although a practice discarded by many physicians by the mid-nineteenth century, bloodletting was still widely available as a treatment for any type of illness, making it hard to define Taylor's actions as self-mutilating.33 Thus, although her sudden unexpected need for bloodletting was regarded as unusual, it was presented as little different from a compulsion to bathe; it was the perceived lack of reason and the 'supernatural voices' heard, rather than the behaviour itself, which was seen to evidence mental illness. Some twenty years later, George Joblin also reported injuring himself to 'relieve the pressure in his head'; while as late as 1900, 56-year-old Alexander McCullock declared 'that he had bled himself with a razor, because medical men were not now allowed to bleed and this relieved his head'.34 This alternative physiological understanding of self-mutilation did not require any specific information as to whether the injuries themselves were in any way painful: even if they were, this could simply be dismissed as a side-effect of treatment.

When self-injury was declared to relieve pain, what did such an idea actually mean? Today, we tend to interpret physical pain as providing potential relief from mental suffering, but these distinctions are hard to draw in nineteenth-century cases. Elizabeth Taylor, for example, spoke of 'relief' to her head, which might have indicated the easing of physical pressure (for she complained of frequent headaches) or of unspecific mental strain. Such conflation is particularly evident in the case of one young student admitted to Bethlem in 1889, when multiple explanations appear in the casebook for the same act. A private attendant prior to hospitalization stated that Charles Hipwood had cut his face because 'he liked to see the blood that followed'. Hipwood's mother, meanwhile, claimed her son told her he cut himself because 'he wanted to see if he could feel anything'. Yet, in Bethlem, an alternative explanation was implied. Although the doctors found it hard to get anything out of their patient at all, he did tell them 'that he does not want to live & hints at something dreadful that is going to happen & at great suffering which he will have to bear'. Following this, the doctors conjectured (not deeming his injuries serious enough to be interpreted as suicidal) that 'he is apparently trying to prepare himself [for this] by inflicting pain on himself now'.35 Both of the latter two explanations emphasize the proximity of physical and mental suffering in a system of medicine which assumed a close relation between bodily and mental states. Charles had apparently told his mother that 'he had been a humbug all his life & unfit to live', that he was 'ungrateful' and 'insensible to anything', following which he cut his face in three places with a knife. Similarly, in 1892, Charlotte Nash Young was reported as having 'said that she had no feeling & cut her arms, thinks that she has no blood in her body […] and bit herself on the wrist

to see if it would bleed'.36The analogy between the biological language of nerves and circulation and the moral language of emotional propriety is apparent in both cases: 'no feeling' might refer to physical sensation or emotional state. Charles Hipwood continued to make a link between nervous and moral breakdown in his letters to Bethlem following discharge, clearly reflecting the contemporary conflation between physical and emotional sensation. Such ideas remain bound up in the approaches outlined below, which, while ostensibly psychological in tone, were nonetheless rooted in the foregoing physiological debate.

Between Somatic Reasoning and Psychological Meaning

When James Adam wrote of 'sexual self-mutilation', he referred his readers to the Psychopathia Sexualis of Richard von Krafft-Ebing, first published in German in 1886 (Adam, p. 1150). But what approach would interested parties have encountered in Krafft-Ebing's work, and how did it relate to the classifications of British alienists like Adam? Acknowledging the influence of Griesinger, Krafft-Ebing readily accepted the idea that self-inflicted injury resulted primarily from the failure of asylum patients to feel physical pain. However, a generation younger, Krafft-Ebing's writings were influenced by shifting ideas in Western European thought: most obviously, a commitment to altruism, emotion, and social feeling as the primary factors in the development of civilization. These concerns increased the use of parallels between physical and emotional sensation, while emphasizing the importance of sensation in the maintenance of social order.37 It is for his work on sexual pathology that Krafft-Ebing is best remembered today, and there has been much historical interest in his writings on homosexuality in particular.38 Less attention, however, has been paid to the way in which early editions of his magnum opus, Psychopathia Sexualis, created categories of pathology based on sensation. Such included both sexual hyperaesthesia (excessive sexual feeling) and anaesthesia (absence of feeling). The latter appeared particularly threatening to late nineteenth-century civilization, for Krafft-Ebing justified his research by building on the suggestions of British alienists (specifically Henry Maudsley) that sexual feeling formed the basis for social advancement, claiming that

> sexual life is no doubt the one mighty factor in the individual and social relations of man that discloses his powers of activity, of acquiring property, of establishing a home, and of awakening altruistic sentiments toward a person of the opposite sex, toward his own issue, as well as toward the whole human race.39

When broken down, such a statement can appear mystifying to a twenty-first-century reader in some areas (what can sex have to do with acquiring property?) and exaggerated in others. Yet many of his claims are closely connected to the ideas of his contemporaries: Darwin, Spencer, and well-known evolutionary anthropologists had all viewed the development of 'sympathy' or 'altruistic sentiments' as the highest achievement of mankind.40 Maudsley and other alienists claimed that such sentiments were developed in puberty, thus assuming

that the acquisition of moral feeling was closely associated with physical (sexual) development.41

So, how did Krafft-Ebing incorporate self-inflicted injury into this model? Although the categories of 'sadism' and 'masochism' were added to the 1890 edition of Psychopathia Sexualis (and thus available to Adam in writing his 1892 definition of 'self-mutilation'), none of the case-studies referring to self-mutilation appear under these headings.42Instead, the most complete case of 'sexual self-mutilation' is incorporated into 'sexual anaesthesia'. One of Krafft-Ebing's earliest published cases concerned E., a thirty-year-old journeyman painter.43 Krafft-Ebing was called as a medical witness after E. was arrested,

while trying to cut off the scrotum of a boy he had caught in the woods. He reported that he wished to cut it off so that the world would not multiply. Often in his youth, for the same reason, he had cut into his own genitals. (p. 67)

Voicing the Malthusian idea that population growth would inevitably outstrip natural resources, E.'s concerns acted out the fears of many others, for he felt that 'it was better to castrate all children than to allow others to come into the world, and whose only fate would be to endure poverty and misery'. On Krafft-Ebing's testimony, E. was judged insane, and sent to an asylum rather than prison. This judgment meant that E.'s concerns about procreation and the poverty of his own childhood could also be dismissed as irrational. Instead, Krafft-Ebing's emphasis lay in an association between E.'s violent acts (both to himself and others), his lack of desire for 'normal' sexual intercourse, and his personality. Given the writer's strong belief in the altruistic potential of sexual activity, it is hardly surprising that he found E. 'selfish and weak-minded', 'moody, defiant, irritable' and a lover of solitude. Conclusively, Krafft-Ebing declared that 'social feelings were absolutely foreign to him' (Krafft-Ebing (1999), p. 68). Interestingly, E. did, in fact, feel physical pain: Krafft-Ebing noted that the patient's attempts at 'self-emasculation' had not been carried out because of pain. Nonetheless, this brief note was not allowed to detract from an overall correlation between the absence of physical (sexual) feeling and a lack of emotional and social feeling. Reports in British journals made similar analogies in cases of self-mutilation. When a young farmer, Isaac Brooks, was reported as having twice attempted to castrate himself in 1882, medical journals saw Brooks's 'eccentric, solitary, and reserved habits' as having led directly to self-injury: his lack of social (and thus, it was assumed, physical) feeling was viewed as having precipitated the act.44

This correlation between physical and emotional anaesthesia was also frequently made in the diagnosis of hysteria in the same period. Cutaneous anaesthesia was regarded as a common symptom of nervous illness, and doctors in hospitals for nervous diseases (such as the National Hospital at Queen Square) frequently carried out sensa-

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tion tests on their patients with the use of a pin. Despite commenting on the suggestibility of hysterical subjects, these physicians seemed to see little problem in searching for anaesthesia, with the result that, according to Sydney Coupland at the Middlesex Hospital, they usually found it (Coupland, p. 644). Such an approach occurred in asylums as well as general hospitals, with the location of physiological symptoms at times overruling the subjective experiences of the patient.

Edith Mary Ellen Blyth was admitted to Bethlem in February 1893, aged thirty. She had been considered to be suffering from hysteria for five years prior to her admission to Bethlem with a diagnosis of mania, during which time she was seen by 'over 20 doctors' for an apparent skin disease, until 'last June [she] was taken to Mr Treves who said the sores were self-inflicted and they ceased to appear soon after this'. Edith was admitted to Bethlem for the most part, it seems, due to her renewed engagement in acts of self-mutilation. Nonetheless, her case certainly did not seem to prove the oft-posited link between self-inflicted injury and anaesthesia: the 'hysterical symptoms' to which she had been subject for eleven years — 'inability to walk, to see, to speak & faints' — did not include a loss of sensitivity to pain. Indeed, Edith gave clinical assistant Dr Rivers a detailed account of her injuries, which, she reportedly said, 'were done by scraping with a pair of scissors, and rubbing in ammonia afterwards. [...] The process was accompanied with considerable pain but that she felt an uncontrollable impulse to do it.' Subsequent to admission, however, Edith's sensibility was examined using a pin and it was claimed that much 'anaesthesia and hemianalgesia' was found: the patient's subjective claim that she felt pain could now be doubted — and even discarded.45

Rivers' detailed account of Edith's case is just one among many examples which indicate that the main interest for many doctors lay in the history of the injury itself (when, where, and how it was created) and the details of treatment leading to the discovery of self-infliction.46 Indeed, while the above quotation appears to indicate some interest in *why* Edith might have inflicted injuries upon herself, in the full case notes this is subsumed within a detailed account of the 'when' and 'where', and is nowhere the main focus of enquiry. The patient's claim that her self-inflicted injuries were the result of forces she could not control does not appear to have been accepted. Rather than either regarding her injuries as irrational symptoms of mental illness *or* exploring any deeper psychological meaning in the infliction of her wounds, much of Edith's treatment appears to have been explicitly moral (in both senses of the word). Both Rivers and his colleague Maurice Craig repeatedly tried to impress upon the patient that her actions were 'wrong', puzzled by her insistence that she had no intention of deceiving anybody and never realised for one moment she was doing anything she ought not to do and thought the remedies prescribed for her would cure her. When shewn the folly of this she said she 'did not put two and two together.' She recognises that it is a disgraceful thing to

have such injuries but thinks she has done nothing wrong because she could not help it.47

The implication here is that, although Edith might have been certified insane (and thus irrational), she could, nonetheless, control her behaviour. Indeed, further notes regularly complained about the patient's troublesome behaviour in the asylum, where she consistently bit, scratched, and attempted to set fire to herself, and she was discharged uncured after less than eight months (the rules of Bethlem usually allowed patients at least a year of treatment). Although the attitude was perhaps kinder than that of Edith's mother who 'for 3 years [...] has suspected that [...] [Edith] made the sores on her legs worse & has not been sympathetic in any way', the understanding of Edith's self-mutilation was located within the widespread medical and popular view of the hysterical patient as manipulative and attention-seeking.48

The connection between self-inflicted injury, absence of pain, and 'selfish' behaviour was drawn most explicitly in William James's well-known paper on emotion.49 James's theory of emotions, published in *Mind* in 1884 and incorporated into his well-known textbook, *Principles of Psychology* (1890),has influenced much twentieth-century work on the topic.50In what is often regarded as an unusually materialistic stance, James suggested that, rather than accompanyingemotional ideas, physiological change in the body preceded — and even *caused* — emotional feeling. Despite much disagreement at the time, and the existence of a number of opposing theories, James's view has dominated much twentieth-century Anglo-American thought on emotions and affect, in particular Robert Plutchik's well-known 'basic theory of emotions', which suggested an evolutionary 'fight or flight' component to human feeling.51 Drawing a parallel between normal and abnormal psychology, James suggested that his theory might be supported by observing the behaviour of individuals who experienced no physical sensation. Indeed, it would prove a 'strong presumption' in favour of his hypothesis if a 'case of complete internal and external corporeal anaesthesia, without motor alteration or alteration of intelligence except emotional apathy' were found. The obvious starting point here, for James, was the asylum, and he referred to several articles by contemporary German alienists as a hesitant test of his theory, before calling for 'asylum-physicians and nervous specialists [to] begin methodically to study the relation between anaesthesia and emotional apathy' (James, pp. 203–04). Self-inflicted injury would, no doubt, have seemed an obvious starting point.

Conclusion

It does not appear that James's suggestions for further study were taken up to any extent, at least in British asylums. Nonetheless, they formed part of a system of medical (and lay) understanding which claimed a close relation between physical and psychological feeling: with insanity often char-

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acterized as showing an absence of both. This, as I have argued, was one of the important areas in which self-mutilation was distinguished from suicide, although the two topics certainly remained related. Self-inflicted injury was initially suggested by Griesinger and other physiological psychiatrists to be an objective symptom of insanity due to its assumed relation to absence of pain (a model of feeling not necessarily posited in cases perceived to be suicidal, which were more often understood in relation to a rational model of suicide as an *escape* from pain). Nonetheless, such ideas were complicated within British asylum practice by the emphasis on self-mutilation as a response to both an absence and an *excess* of pain. As the use of asylum case-books in conjunction with published texts has indicated, the reporting of cases of self-mutilation cannot be seen simply as a description of the realities of asylum life. Instead, reports of self-mutilation were constructed by patients and doctors in a multi-layered process, drawing on the prior experiences reported by the patient, medical views of the role of sensation and its absence in mental disorder, and the cultural significance of emotional and moral feeling. This socio-environmental approach to self-mutilation is apparent in the approaches of physicians towards other symptoms of mental illness, such as the 'sexual anaesthesia' of Richard von Krafft-Ebing. It did not, moreover, preclude censure of the patient — as in the case of Edith Blyth — suggesting that absence of feeling was deemed to be located in the individual's biology or character, as well as in their socio-environmental context. Nonetheless, the two approaches were mutually constitutive: situating the onset of the individual's disorder in social concerns *as well as* regarding the insane individual as a potential danger to social order. For some writers in the late nineteenth century, as I have shown elsewhere, self-mutilation became synonymous with 'selfishness': an inability to respond to the 'altruistic sentiments' regarded as vital for the progress of civilization.52 This did not, however, rule out the simultaneous interpretation of self-inflicted injury as a response to emotional (societally created) pain. In either instance, however, it is impossible to draw a sharp distinction between physical and emotional pain, both within the topic of self-mutilation and in wider psychiatric discourse, opening up broader questions about the relationship of body to mind in psychological medicine in the late nineteenth century.

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1. James Adam, 'Self-Mutilation', in *A Dictionary of Psychological Medicine*, ed. by Daniel Hack Tuke (London: Churchill, 1892), pp. 1147–52; P.

2.See Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* (Baltimore: Johns Hopkins University Press, 1996), pp.

243–53; E. David Klonsky, 'The Functions of Deliberate Self-Injury: A Review of the Evidence', *Clinical Psychology Review*, 27 (2007), 226–39.

3. Scarry, in contrast, assumes that the relief of one pain by another must be the substitution of physical for psychological pain (pp. 33–34). See also Roselyne Rey, *History of Pain* (Paris: La Découverte, 1993), pp. 105–07.

4. Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), p. 11.

5. See Maury Deas, 'The Uses and Limitations of Mechanical Restraint as a Means of Treatment of the Insane', *Journal of Mental Science*, 42 (1896), 102–13.

6. Karl A. Menninger, *Man Against Himself* (San Diego: Harcourt Brace Jovanovich, 1985), pp. 201–308.

7. Favazza, p. 232. See also Margaret McAllister, 'Multiple Meanings of Self Harm: A Critical Review', *International Journal of Mental Health Nursing*, 12 (2003), 177–85; Barent W. Walsh and Paul M. Rosen, *Self-Mutilation: Theory, Research, and Treatment* (New York: Guilford Press, 1988); P. M. Rosen and B. W. Walsh, 'Patterns of Contagion in Self-Mutilation Epidemics', *American Journal of Psychiatry*, 146 (1989), 656–58; B. Parry-Jones and W. L. Parry-Jones, 'Self-Mutilation in Four Historical Cases of Bulimia', *British Journal of Psychiatry*, 163 (1993), 394–402.

8. A forthcoming article by Åsa Jansson makes an important step towards filling this gap in scholarship, highlighting the way in which historians have assumed the existence of a 'real' number of suicidal asylum patients, thus failing to explore how the idea of a person *being* suicidal emerged. Åsa Jansson, 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Medicine', *Journal of Social History*, 46 (2013, forthcoming). For previous work, see, in particular, Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon Press, 1987), pp. 263–417; Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, 46 (2002), 175–96.

9. G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1995), pp. 443–54.

10. Barbara J. Brickman, '"Delicate" Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse', *Body & Society*, 10 (2004), 87–111; C. Millard, 'Self-Mutilation and a Psychiatric Syndrome: Emergence, Exclusions & Contexts (1967–1976)' (unpublished master's thesis, University of York, 2007).

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11. This question was not altered until Bethlem belatedly became incorporated under the Lunacy Acts in 1853, and the reception order required under the 1845 Act (which referred only to suicide) was adopted.

12. 'The Case of the Farmer Brooks', *The Lancet*, 119 (1882), 73. Newspapers repeated this quotation verbatim. See, for example, F. W. Warrington, 'The Strange Confession in Staffordshire', *The Times*, 13 January 1882, p. 10.For more background on the emergence of the term, and the types of behaviour to which it referred, see Sarah Chaney, 'Self-Control, Selfishness and Mutilation: How "Medical" is Self-Injury Anyway?', *Medical History*, 55 (2011), 375–83; Sarah Chaney, '"A hideous torture on himself": Madness and Self-Mutilation in Victorian Literature', *Journal of Medical Humanities*, 32 (2011), 279–89.

13. T. N. Brushfield, 'On Medical Certificates of Insanity', *The Lancet*, 115 (1880), 711–13; Henry Rayner, 'Melancholia and Hypochondriasis', in *A System of Medicine*, ed. by T. Clifford Albutt (London: Macmillan, 1899), pp. 361–81; Maury Deas, pp. 102–13.

14. 'Asylum Reports for 1871', *Journal of Mental Science*, 18 (1872), 262–76 (p. 274).

15. For this distinction between suicide and self-homicide, see Rayner, p. 369.

16. J. A. Mangan and James Walvin, *Manliness and Morality: Middle-Class Masculinity in Britain and America, 1800–1940* (Manchester: Manchester University Press, 1987).

17. Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, ed. by Benjamin Giles King (London: Pickering and Wilson, 1823), p. 1; Alexander Bain, *The Emotions and the Will* (London: Parker, 1859), esp. pp. 31–35 and pp. 336–50.

18.

Lorraine J. Daston, 'The Theory of Will versus the Science of Mind', in *The Problematic Science: Psychology in Nineteenth-Century Thought*, ed. by William Ray Woodward and Mitchell G. Ash (New York: Praeger, 1982), pp. 88–115; Robert M. Young, *Mind, Brain and Adaptation in the Nineteenth Century* (Oxford: Clarendon Press, 1970), pp. 101–33.

19. R. von Krafft-Ebing, *Text-Book of Insanity: Based on Clinical Observations for Practitioners and Students of Medicine* (Philadelphia: Davis, 1904), p. 120.

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21. For a history of the latter idea see Roger Smith, *Inhibition: History and Meaning in the Sciences of Mind and Brain* (London: Free Association Books, 1992).

22. W. C. McIntosh, 'On some of the Varieties of Morbid Impulse and Perverted Instinct', *Journal of Mental Science*, 11 (1866), 512–33 (p. 528).

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32. BRHA, *Female Patient Casebook 1860*, p. 39 (CB/77).

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